

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/17/2012

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155176		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011	
NAME OF PROVIDER OR SUPPLIER GLENBROOK REHABILITATION & SKILLED NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3811 PARNELL AVE FORT WAYNE, IN46805			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 12/20/11</p> <p>Facility Number: 000092 Provider Number: 155176 AIM Number: 100266090</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Glenbrook Rehabilitation & Skilled Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a basement was determined to be of</p>			K0000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered as the letter of credible allegation and request a desk review in lieu of a post survey review on or after January 13, 2012.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0015 SS=B	<p>Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 90 and had a census of 69 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/22/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			K0015	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified to be affected by alleged deficient practice. How will you identify</p>		01/13/2012
	<p>Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure the interior finish for 1 of 3 medical records storage areas has a flame spread rating of a Class A,</p>						

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K0025 SS=E	<p>Class B or a Class C finish. This deficient practice was not in a resident care area but could affect any number of staff.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor on 12/20/11 at 12:30 p.m., two walls in the basement medical records storage room were covered with paneling. Based on an interview with the Environmental Supervisor at the time of observation, he stated there was no documentation available to demonstrate the paneling provides a flame spread rating of a Class A, Class B or a Class C finish.</p> <p>3.1-19(b)</p>				<p>other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: The walls in the basement medical records storage room were the only paneled walls in the facility. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur: The paneling on the two walls in the storage room was removed and replaced with drywall. How the corrective action will be monitored to ensure the deficient practice will not recur. i.e. what quality assurance program will be put in place: Paneling will not be placed on walls in the facility unless it has a flame spread rating of a Class A, Class B, or a Class C. Environmental Supervisor and/or designee will monitor for compliance on quarterly basis and report any deficient practices to the CQI committee.</p>		
	<p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and</p>			K0025	What corrective action will be		01/13/2012

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	<p>interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect residents at the north and south nurses' station and any number of kitchen staff.</p> <p>Findings include:</p> <p>Based on observations with the Environmental Supervisor on 12/20/11 from 1:50 p.m. to 1:55 p.m., louvered attic exhaust vents were located at the north and south nurses' station as well as in the kitchen. The louvers did not close completely leaving one fourth inch gaps. Based on an interview with the Environmental Supervisor at the time of observations, the vents were open to the attic and no longer in use.</p> <p>3.1-19(b)</p>			<p>accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: The three louvered exhausts fans identified were the only ones located in the facility. What measures will be put in place or what systemic changes will you make to ensure the deficient practice does not recur: Environmental Supervisor sealed exhaust vents from the bottom so that there is an appropriate smoke barrier in place. How the corrective action will be monitored to ensure the deficient practice will not recur. i.e. what quality assurance program will be put in place: Environmental Supervisor and/or designee will monitor for compliance on quarterly basis and report any deficient practices to the CQI committee.</p>			